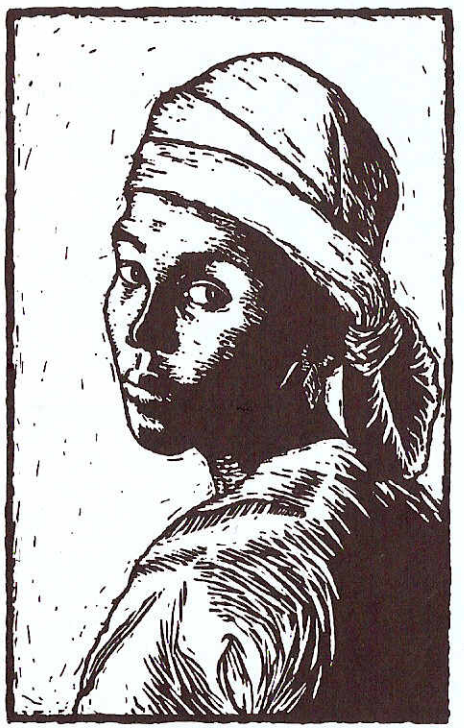
Critical Perspectives in Health and Social Justice



WOMEN, POVERTY & AIDS

An Introduction

Institute for Health and Social Justice
April 1994

Series 1 ◆ Paper 1

Critical Perspectives in Health and Social Justice

1 ◆ **Women, Poverty and AIDS**
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Critical Perspectives in Health and Social Justice are prepared by the staff of the Institute for Health and Social Justice and edited by Bill Rodriguez.

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Partners In Health is a 501(c)(3) organization and all contributions are tax-deductible.

Cover art by Katy Farmer and Robert Dellinger

WOMEN, POVERTY, AND AIDS
An Introduction

In 1981 the term AIDS entered the medical lexicon when physicians in New York and California noted clusterings of unusual infections and cancers in several patients. These patients were almost exclusively young men, who had not previously been known to be susceptible to such "opportunistic" infections—infections that a normal immune system would control. As more cases were identified, this lethal new immunodeficiency syndrome entered the public discourse as well— primarily as a disease of its most prominent early victims, young gay men.

Since that time, however, it has become increasingly apparent that women are vulnerable to AIDS. Most now agree that HIV, the virus that causes AIDS, is much more efficiently transmitted from men to women than from women to men. These self-evident truths have been belittled by a number of observers, some of whom have argued that women will never constitute a significant portion of AIDS victims. The Myth of Heterosexual AIDS, published by a major commercial publisher in 1990, is typical of this sort of thinking. In it, we can read such statements as:

> among the great wide percentage of the nation the media calls 'the general population,' that section the media and public health authorities has tried desperately to terrify, there is no epidemic. AIDS will pick off a person here and there in the group, but the original infected partner will be one of the two groups in which the disease is epidemic [viz., gay men or intravenous drug users]. Most heterosexuals will continue to have more to fear from bathtub drowning than from AIDS.

Grammatical mistakes and a lack of compassion aside, the glaring error here goes beyond false predictions. Even as such

projections were written, in the United States at least 100,000 women were *already* "picked off" by HIV, 34% of whom had no known risk factor other than heterosexual sex. In many sub-Saharan African countries, where more than 4,000,000 women are affected, there are currently more infections among women than among men. In fact, in most countries from which data are available, an inordinate number of new infections are among women. To give just a few of the current projections:

◆ It is now estimated that women constitute 40% of the world's HIV-infected population. In 1992, the United Nations Development Program wrote that "each day a further three thousand women become infected, and five hundred infected women die." It is believed that women will comprise over half of all infected persons by the year 2000.

◆ AIDS has become the leading cause of death among young women of color in several U.S. cities.

◆ In some regions, AIDS is exploding among adolescent girls. In Uganda, the rate of new infection among girls aged 15 to 19 is six times higher than that for boys of the same age. Similar patterns have been reported in Malawi and Zaire. A significant portion of U.S. women are diagnosed with AIDS in their twenties, suggesting that infection may have occurred during adolescence.

◆ Studies among asymptomatic pregnant women in poor quarters of Port-au-Prince, Haiti, Kinshasa, Zaire, Kampala, Uganda, and New York City have revealed rates of HIV seropositivity ranging from 10% to 25% of those surveyed.

◆ In the United States, the epidemic among women is increasing at a much higher rate than that registered among any other group. Identical patterns have developed in other areas of the world initially characterized by a male preponderance: in one city in

Finally, all of these AIDS-focused activities may not in themselves have a telling effect on the rate of HIV transmission to women. Such events, though crucial, must be linked to efforts to empower poor women. This means a more equitable sharing of their fruits of this earth. This means calling for political changes that would protect women from the legal and social traps to which they are vulnerable— landlessness, joblessness, lack of access to health care and education. These are the factors that sap women's ability to control sexual encounters.

Following the example offered by the theology of liberation, we would argue that one important way to confront AIDS would be to make an "option for the poor." As the proponents of this philosophy have noted, this means struggling with the poor against their oppression. As far as women and AIDS are concerned, this implies making common cause with women attempting to organize themselves not just against AIDS, but against the forces that rob them of control over their bodies and their lives.

For bibliographic references or other information regarding women, poverty, and AIDS, please contact :

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The IHSJ would like to thank Anitra Pivnick for contributing material to this essay.

targeted to women have to date focused on commercial sex workers or women reporting to prenatal clinics. But, as one scholar has noted, women at risk of AIDS are "more than mothers and whores." In many settings, especially among the poor, women at risk are simply those who are sexually active; quite often, they are strictly monogamous.

Prevention campaigns will be different in different settings. In most parts of the world where AIDS is endemic, women have been kept from learning to read and write; these women do not have access to television or radio. Developing appropriate messages will necessarily be difficult, and must be linked to broader schemes to empower poor women.

Of course, improved clinical services are important as well. This means, among other things, educating health care professionals about women and AIDS. It means rethinking diagnostic criteria for AIDS and including symptoms and clinical manifestations specific to women. It means redirecting research money into topics of relevance to women with HIV disease. It means improving services to women with HIV infection, and respecting their decisions about childbearing.

Can the masculinization of AIDS services be overcome? Writing from the United States, where resources exist but are inequitably shared, Martha Ward sounds a pessimistic note in this regard:

> AIDS programs for poor women continue to offer little but palliative solutions. Service providers have a continuing orientation to middle class values, and it is hard for them to see that behaviors such as drug dealing and substance abuse might be adaptive. The programs for women do not have the vitality or originality of those for gays; they are only puny grafts on an already taxed health care system. Furthermore, these programs can do nothing to address the overarching problems of racism, classism, and sexism.

West Germany, the percentage of HIV-infected persons who are women rose from 4% in 1984 to 25% in 1988. Among Mexican women, an almost identical trend was registered during the same time period.

Why, then, do some continue to think of AIDS as a disease of men? We may understand how this gross misperception came about— the disease entered the public spotlight as it ravaged the gay male community— but why has it persisted? Why have the voices of infected women been absent from scientific and public commentary a full decade into the pandemic?

Many would argue that it has remained possible to maintain such a silence because the majority of women infected with HIV were already isolated from public debate. In communities where racism, elitism, and sexism are entrenched, HIV has affected women of color, poor women, and, simply, women— robbed of their voices long before AIDS appeared to further complicate their lives.

Modern Mythology: The New Scarlet Letter

Poverty, racism, and sexism are powerful social forces that exclude many HIV-infected women from the debate; we will focus on the role of poverty in the spread of HIV among women later in this essay. First, however, it will be useful to look beyond these familiar forces to identify the specific myths that have developed around HIV and women.

We have already exposed the myth that *AIDS is a disease of men* by citing the data to suggest that not only was this never the case, but that in the future AIDS may become a disease afflicting women predominantly.

Another related myth— *heterosexual AIDS won't happen*— has been proved false by recent history. Heterosexual AIDS has already happened. The data tell us that in many parts of the world, AIDS is now the leading cause of death among young women. In sub-Saharan Africa, the Caribbean, and Southeast Asia,

more than 70% of those with HIV disease have no risk factor other than heterosexual activity.

Even while myths depicting AIDS as a gay male disease have held sway, the limited recognition of women with HIV disease that exists has been laden with stigma and misportrayal. Some women with HIV have been stereotyped as prostitutes—"AIDS Assassins," according to one television talk-show host.

Not surprisingly, there have been a number of seroprevalence studies investigating the rate of HIV infection among sex workers in various parts of the world. These studies have revealed rates ranging from less than 5% in Somalia to almost 90% in Kenya. In a curious example of sociologic acrobatics, such data have been used to suggest that *men* are at risk of contracting HIV from sex workers, rather than the more obvious interpretation that these women have been placed at risk by their socioeconomic ties to the sex trade.

This myth of *women as vectors*— modern Hester Prynnes who wittingly or unwittingly infect men and "innocent babies"—has been particularly damaging. Prostitutes have been vilified by such propaganda, and yet one would be hard-pressed to identify a single case in which a man can be shown to have contracted HIV infection *from* a specific sex worker. Conversely, AIDS can be thought of as an "occupational risk" of commercial sex work, especially in settings where sex workers cannot demand that clients use condoms. Some studies suggest that the risk for women to contract HIV from a single heterosexual encounter is up to15 times greater than that for men.

Moreover, the miscasting of this data into terms emphasizing the risk of HIV spread from sex workers to the male community and beyond has led to the development of prevention programs which focus on the use of condoms— *rather than on the development of programs that would address the root causes placing sex workers at risk for contracting HIV in the first place.*

The paradigmatic assertion that "prevention is our only tool" may be linked to the myth of *condom as panacea.* The

stop having sex, or start using condoms, we could solve the AIDS problem"); they give lie to prevalent notions of who is at risk for AIDS ("Promiscuity and prostitution are at the root of AIDS"). Neither Darlene nor Guylene could be considered promiscuous; neither had ever engaged in anything resembling commercial sex work, although both had conceived children in relationships that could not have been understood without an appreciation of the poverty from which they tried to escape.

The stories of Darlene and Guylene would lead us to question the assertion that "condoms can stop AIDS," for surely these narratives call into question the utility of condoms in settings in which women's ability to insist on "safe sex" is undermined by a host of less easily confronted forces. These forces include sexism and a deepening social inequity belied by figures such as national per capita income.

Furthermore, both Darlene and Guylene chose to conceive children, the latter after she became aware of her HIV status. When asked why she had made such a decision, Guylene gave a bitter laugh and noted that the soldier "would never have stayed with me if I didn't give him a child." AIDS prevention methods that overlook the needs and desires of millions of women to conceive are destined to fail.

What Is To Be Done?

The trials of women like Guylene pose challenges to women in rich countries. In settings like rural Haiti and in much of Africa, women need the "pragmatic solidarity" of people of good will in the wealthy nations. Similarly, within rich countries, the struggles of women like Darlene— who received none of her birthright as a citizen of such a wealthy country— stand as a rebuke to those who believe that the United States is at the forefront of care for people with AIDS.

At the same time, such suffering reminds us that the struggle against AIDS must continue. Effective prevention means getting the right message across, and the majority of preventive efforts

The stories of Darlene and Guylene reveal both differences and commonalities in the experiences of poor women with AIDS, whether in rich countries or in poor countries. Guylene's experience, especially, is emblematic of that of most women who are infected with HIV. Similar stories— AIDS in women who have never used IV drugs or had a blood transfusion— are legion in sub-Saharan Africa, and fast becoming commonplace in India, Thailand and other parts of Asia.

Together, these stories call into question the dominant understandings of AIDS, which have not included an appreciation of the mechanisms by which poverty and sexism put poor women at risk of HIV infection. As we have seen, dominant readings of women and AIDS are far more likely to include punitive images of women as purveyors of infection— as prostitutes, for example, or mothers who "contaminate" their offspring— than to portray homelessness, sexism, a dearth of options, multiple barriers to medical care, a social-service network that doesn't work, and an absence of jobs and housing.

Dominant readings are likely to foster images of women with AIDS as promiscuous, but very unlikely to reveal how political and structural violence come to be important in the AIDS pandemic today. The stories of Darlene and Guylene may be considered portraits of vulnerability, but only if it is made clear that these women have been rendered vulnerable to AIDS through social processes. By social processes, we mean economic, political, and cultural forces that can be shown to direct the dynamics of HIV transmission. It is important to remember— and impossible *not* to remember— that both Darlene and Guylene were born into poverty. The dynamics of HIV infection among poor women reveal the complex relationship between power/powerlessness and sexuality.

What are the implications of these arguments and the experience of Darlene and Guylene? They reveal the importance of attacking myths, such as those that say women have complete control over their bodies and their lives ("If women would just

worldwide focus on condoms obscures the fact that it is men, by and large, who wear condoms. The various forces that conspire to disempower women in sexual activity will surely keep such male-centered methods from becoming truly successful barriers to HIV infection among women.

Even the manner in which children with HIV are discussed censures women. Those with HIV-positive children have been considered guilty of infecting their innocent offspring. Anthropologist Martha Ward has argued that

> the term 'pediatric AIDS' is popular because it obscures the powerlessness of being poor and conjures pictures of innocent infants. This generates more compassion and more energy than the idea of women infected through sex and drugs. But the term trivializes and stigmatizes the lives of infected mothers.

These issues are not insignificant to women with AIDS. In 1992, the International Community of Women Living with HIV/AIDS issued a list of twelve demands to improve their lives; the second demand was that "media realistically portray us, not stigmatize us."

'I Got Real Problems'

A central effect of much of the professional commentary on women and AIDS, and the myths generated from it, has been to obscure the impact of poverty. Casting women as agents of transmission of the disease, and then shaping prevention efforts around this model, obfuscates the more germane discussion as to what predisposes women to HIV infection in the first place.

Although many people working directly with HIV-infected women and on AIDS prevention efforts would agree that forces such as poverty, sexism, and racism are the strongest enhancers of risk for exposure to HIV— as would most of those infected— these subjects have been neglected in the biomedical literature of HIV infection. Take, for example, a recent seroprevalence survey

of HIV infection in rural Florida designed to detect the rate of HIV infection in asymptomatic women. Published by Ellerbrock and coworkers in the *New England Journal of Medicine*, the study revealed that over 5% of 1,082 women attending a public prenatal clinic in rural Florida have antibodies to HIV, indicating the presence of infection.

What "risk factors" might account for such a high rate of HIV infection in asymptomatic women who considered themselves healthy? The researchers reported a statistically significant association between HIV infection and having used crack cocaine; having had more than five sexual partners in a lifetime; having exchanged sex for money or for drugs; and having had sexual intercourse with a "high-risk partner."

These associations are not surprising. But the conclusions drawn by the authors are quite surprising. The study concludes that, "in communities with a high seroprevalence of HIV, like this Florida community, a sizable proportion of all women of reproductive age are at risk for infection through heterosexual transmission."

Is this conclusion accurate? In settings with an even higher seroprevalence of HIV, such as New York City, not *all* women of reproductive age are at increased risk of acquiring HIV; rather, *poor women* are at highest risk. Although the United States is unique among industrialized countries in its refusal to gather mortality data by income, a survey of AIDS deaths among women in New York reveals that 80% of them have occurred in the city's poorest neighborhoods.

And, while the majority of these women are Hispanic or African-American, it is not their race but their class which correlates with HIV seroprevalence. To again cite Martha Ward:

> The collection of statistics by ethnicity rather than socioeconomic status obscures the fact that the majority of women with AIDS in the United States are poor. Women are at risk for HIV not because they are African-American or speak Spanish;

soldier had only been in the region about a month. Although residents of Peligre said that he had a regular partner in that village as well, Guylene insists that she was his only partner in the region:

> He saw me here, at home. He saw me only a couple of times, spoke to me only a couple of times, before announcing that he cared for me. After that, he came to visit me often. I didn't think much of it until he started staying over. I got pregnant at about the time they announced that he was being transferred back to [his home town]. He said he'd be back, but I never saw or heard from him again.

Because Guylene's physicians had gone to some trouble to prevent her from having unprotected sexual intercourse, they were anxious to know how conversations about this subject may have figured in her decision to conceive another child. That Guylene understood what it meant to be an asymptomatic carrier of HIV seemed clear from a metaphor she used to describe herself:

> You can be walking around big and pretty, and you've got a problem inside. When you see a house that's well built, inside it's still got ugly rocks, mud, sand— all the ugly, hidden things. What's nice on the outside might not be nice on the inside.

Guylene understands, too, that her child might well be sick with HIV infection. But she is impatient with questions, tired of talking about sadness and death: "Will the baby be sick? Sure he could be sick. People are never *not* sick. I'm sick . . . he might be sick too. It's in God's hands."

Now Guylene draws to the close of her fifth pregnancy, which may well culminate in another death. Two of her children are dead; two others have long looked to a father or grandmother for the bulk of their parenting. Guylene's own sisters are dead, missing, or beaten into submission by the hardness of Haiti. Few of her nephews and nieces have survived into adulthood. Guylene assures her physicians that she is without symptoms, but seems inhabited by a persistent lassitude.

◆

A month after her confinement, Guylene returned to Savanette with the baby. She was unemployed; her mother and sister were barely making ends meet. Guylene and others in the household often went hungry. Feeling as if she were a burden, Guylene finally went to the coastal town of Saint-Marc, where she had cousins. She worked as a servant in their house until the baby became ill; Guylene, too, felt exhausted. Since medical care was freely available only in Do Kay, she returned again to Osner's mother, who offered to take the baby. Guylene's and Osner's first child had already started school there and Osner's mother allowed she could always find food for one more.

By the spring of 1992, Guylene was ill: she was always fatigued, had lost weight, and eventually stopped having her periods. In June, 1992, she went to the clinic in Do Kay, where a doctor heard her story with some alarm. Yes, she had heard of AIDS; some had even said that Osner had died from it, but she knew that wasn't true. After reviewing Osner's chart, the physician suggested that she be tested for HIV. She was leaving for Port-au-Prince, Guylene informed him, but would return for the results.

When Guylene returned to Port-au-Prince, the city was in the throes of its worst economic depression in recent decades. She worked a few days as a maid, but found the conditions intolerable. She tried selling cigarettes and candy, but remained hungry and fatigued. "I was ready to try anything," she said. Back in the village, Guylene's fourth baby died quite suddenly of cardiac failure, presumed secondary to the effects of HIV. Although the child had never been tested for the presence of the virus, Guylene's test had come back positive a few days earlier.

Guylene was informed of her positive HIV test on the day following her return; she listened impassively as a physician went through the possible significance of the test and made plans to repeat it. Careful physical examination and history suggested that Guylene had not yet had a serious opportunistic infection.

Guylene began visiting the clinic regularly. She was placed on medications to prevent infections and vitamin supplements, and also a protein supplement. She did not return to Port-au-Prince, but rented a house with the financial aid she received through the clinic. Although Guylene experienced significant improvement in less than a month, she remained depressed and withdrawn. A young man named Rene began visiting her, but Guylene discouraged him and he disappeared— "he went to Santo Domingo [to cut sugarcane], I think, because I never heard from him again."

In mid-November, however, Guylene responded to the advances of a soldier stationed in Peligre. A native of a large town near the Dominican border, with a wife and two children there, the

women are at risk because poverty is the prior and determining condition of their lives.

A closer look at the language in which the *New England Journal of Medicine* study's conclusions were couched suggests that a meaningful discussion of risk cannot be limited to narrowly construed issues. Nowhere in this article does the word "poverty" appear; this, despite the fact that the authors note that over 90% of the women who knew their incomes belonged to households earning *less than $10,000 per year*. In a real sense, AIDS has come to complicate the lives of women already beleaguered by poverty, sexism, and racism.

As one HIV-positive woman interviewed by Martha Ward in Louisiana put it: "You think AIDS is a problem? No way. I got real problems."

Getting at the Right Questions

If we pursue our own conclusions that only certain subgroups of women are at risk for HIV infection, we must ask: how, precisely, do social forces such as poverty, sexism and other forms of discrimination become translated into risk? By what mechanisms do most seropositive women come to be infected with HIV? If not all women are at high risk, which groups of women are most likely to be exposed to the virus?

We propose to address these questions in part by examining the experiences of two women with AIDS. "Darlene" is an African-American woman from Harlem; "Guylene" is the daughter of poor peasants from rural Haiti. At this writing, both women are living with HIV infection. Their stories, similar in some ways and different in others, speak to many of the questions raised above.

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Darlene

Darlene Johnson, a slight, thirty-five year old woman interviewed in a methadone clinic, was born in central Harlem in 1955. She was one of three children born to a mother who was

chronically homeless, and who left her husband and children for long periods of time. Darlene isn't certain why her mother kept leaving, although she remembers her parents having terrible fights in which her father hit her mother, and her mother cried for days.

When Darlene was five, her mother sent her to Alabama to stay with her maternal grandmother. She did not return to New York City until she was eleven. She was then sent by her mother to the care of her brother, ten years older than she. This arrangement was difficult, Darlene remembers, because her brother, responsible at the age of 21 for an eleven year-old sister, was angry and took it out on her by beating her frequently. Darlene lived with her brother in Harlem until she moved in with her first husband. "I finished eleventh grade," Darlene says, "and then I left school to be with a man."

Darlene and her husband had two children, a boy and a girl, in quick succession. But their marriage soon began to founder. The problem, she recalls, was their mutual passion, not for each other, but for heroin, which Darlene first used at the age of 13. The couple remained together for six years. Then, feeling that her marriage was dangerous to herself and her children, Darlene decided to leave and went with her children to live with her father.

A short while after moving in with her father, Darlene met her second husband. This second marriage was for love. Her husband, also a heroin user, worked. They had two sons, and her two older children also loved this man. Darlene insists that, although she used heroin, it didn't interfere with taking care of her children. "It just made things smooth," she said.

In 1987 Darlene's stepbrother, also a heroin user, was diagnosed with AIDS. He died quickly, Darlene says; no mess, no fuss— "he just died." The family was shocked, and shortly after her stepbrother's death, his father had a heart attack and died. He, too, was found to be HIV-infected.

Darlene grieved and resolved to keep her family together. But her husband began to have high fevers and night sweats. He refused to go to the doctor; Darlene, tortured by the memory of the times that she, her husband, and her stepbrother had shared needles, knew it must be AIDS. It was: she was tested and was found to be HIV-positive. Her husband died two months later.

Darlene suspected that her youngest son, sick from birth with a variety of ailments, was infected as well. His first serious bout with pneumonia made everything clear: this child had AIDS and Darlene would have to watch him die, too. By her own account, she was in a state of shock. "Too many close people" had died.

Darlene was now alone with four children. She had lost her husband, her stepbrother, and her stepfather in a single year. Two

often short of work: he worked in a garage; she split her time between jobs as a maid and selling fried food on the wharf in Cite Soleil, a notorious slum north of the capital. Guylene much preferred the latter:

> Whenever I had a little money, I worked for myself selling, trying to make [her capital] last as long as I could. When we were broke I worked in ladies' houses . . . If the work is good, and they pay you well, or the person is not too bad, treats you well, you might stay there as long as 6 or 7 months. But if the person treats you poorly, you won't even stay a month. Perhaps you only go for a single day and then you quit.

When asked what she meant by decent pay, Guylene stated that the equivalent of $20 a month was passable, as long as you were able to eat at work.

In 1987, three "unhappy occurrences" came to pass in quick succession. A neighbor was shot and killed during one of the military's regular nighttime incursions into the slum; bullets pierced the thin walls of Guylene's and Osner's own house. A few weeks later, Guylene received word that her son had died abruptly. The cause of death was never clear.

Finally, Osner became gravely ill. It started, Guylene recalled, with weight loss and a persistent cough. He returned to Do Kay a number of times in the course of his illness. Given a young man returning from Port-au-Prince with symptoms of tuberculosis, it was routine practice to consider HIV infection in the differential diagnosis, and it was suggested as a possibility at that time. Osner reported a lifetime total of seven sexual partners, including Guylene. With one exception, each of these unions had been monogamous, if short-lived.

Osner did not respond, except transiently, to biomedical interventions, and died of AIDS in September, 1988. Guylene subsequently returned to Savanette, to a cousin's house. She tried selling produce in local markets, but could not even support herself, much less the child she had left in the care of Osner's mother. She was somewhat humiliated, she said, by having to ask Osner's mother for financial assistance, even though she informed her that she was pregnant with Osner's child.

Finally, a full year after Osner's death, the fetus "frozen in her womb" began to develop. It was, she insisted, Osner's baby (others identified a man from her hometown of Savanette as the child's father). She delivered a baby girl in November of 1989.

mother and two children, working the family plot of land for ever-diminishing returns.

Guylene recounts her own conjugal history in the sad voice reserved for retrospection. When she was a teenager— "perhaps 14 or 15"— a family acquaintance, Occident Dorzin, took to dropping by to visit. A fairly successful peasant farmer, Dorzin had two or three small plots of land in the area. In the course of these visits, he made it clear to Guylene that he was strongly attracted to her. "But he was already married, and I was a child. When he placed his hand on my arm, I slapped him and swore at him and hid in the garden."

But Dorzin was not so easily dissuaded, and in short order approached Guylene's father to ask for her hand, not in marriage, but in *plasaj*, a potentially stable sexual union widespread in rural Haiti. Before she was 16, Guylene moved in with Dorzin, a man twenty years her senior, to a village an hour's distance from her parents. She was soon pregnant. Occident's wife, significantly older than Guylene, was not at all pleased, and friction between the two women eventually led to the dissolution of the newer union. In the interim, however, Guylene gave birth to two children, a girl and a boy.

After the break with Dorzin, Guylene and her infant son returned to her father's house. She remained in Savanette for five months, often passing through the village of Do Kay on her way to the market or to visit her daughter, who remained in Occident's care. It was in these travels that she met a young man named Osner, who worked intermittently in the city as a laborer and mechanic. One day he struck up a conversation with Guylene as she visited a friend in the village. "Less than a month later," she recalled, "Osner sent his father to speak to my father. My father agreed." Leaving her toddler son in her parents' household, Guylene set off to try conjugal life a second time, this time in Do Kay.

The subsequent months were difficult. Guylene's father died later that year, and her son, cared for largely by her sister, was often ill. Guylene was soon pregnant with her third child, and she and Osner lacked almost everything that might have made their new life together easier. After their baby was born in 1985 they decided to move to Port-au-Prince, the capital city: Osner would find work in a garage, and Guylene would become involved in commerce. Failing that, she could always work as a maid. In the interim, Osner's mother would care for the baby, as Do Kay was a far sight safer than Port-au-Prince.

Osner and Guylene spent almost three years in the city. They were hardscrabble times. Political violence was resurgent, especially in the slum areas where they lived. The couple was

women who were her baby's godparents and who had also shared needles became ill and they, too, died. Heroin was doing nothing for her. Crack, she explains, came to be the only way she could get through the day. But there was a price to pay. Darlene became short with her children, raising her voice often, not cooking regular meals for them, happy when they were gone. The system that was supposed to be helping her deal with her loss and the problems she was confronting failed her:

> This social worker was telling everybody I had the virus... The police came looking for me when my little son ran away; he ran away with my big son, my big son brought him home. When I came downstairs, the cops jumped all the way down the stairs. 'Oh, you're supposed to be in the hospital cause you got AIDS.' Everybody on the street [was] looking at me. [The social worker] told my kids' friends, their parents. Little boy was up in the fire escape, he say, `Oh, look— there's David's mother; she got AIDS.'

Darlene, concerned that her children were suffering and neglected, and without a family, turned to the authorities and asked that the three oldest children be placed in foster care while she tried to care for the youngest, dying of AIDS.

> I placed them away because after the baby, and me so depressed, I just didn't want to live any more and I didn't want the kids to be running in the street, to be hungry and clothesless. So I placed them away.

The children went into foster care separately. The oldest was placed in a home in the Bronx, but he ran away to live with a friend of Darlene's who wanted him and who supports him. Darlene knew where he was and didn't tell anyone. Her friend loves him, she said, and the city would never have given her friend custody of him, so she remained silent.

Darlene's daughter was placed with a woman Darlene knew to be a drug user:

> They put my daughter in a house where they sell drugs, crack. My daughter watches this lady's kids. My daughter, I think she's messing with boys. This woman got a case worker herself. My daughter hasn't been in school since they placed her.

Darlene wanted to change the placement, but was powerless to do so.

Darlene's next-to-youngest son was placed in New Jersey with a family that Darlene likes. He is well cared for, and she expects the family to adopt him when she dies. She is grateful for them and wants the adoption to happen.

Alone with her youngest, Darlene found it painful to care for him. The little boy suffered terribly, she recalls. His stomach became more and more distended and he didn't respond to her at all. Finally, one night lying in bed with her, he stopped breathing. He was three years old, and it had taken him six months to die.

Six people in Darlene's life had died in a single year.

Darlene gave in to crack completely and lived on the streets for three months until she decided she couldn't die that way. The children counted on seeing her. She went into the hospital to detoxify from crack and enroll in the methadone program. Once in the program, she saw a doctor. During the previous year, she had never gone to a physician for herself. She thinks she must have been very depressed. She is still depressed, she thinks. She, too, has been diagnosed with AIDS. But that's not it. She worries about her two oldest children. She could have used some help with them when all the deaths began. The social worker was mean. She's not sorry she had her youngest son even though he suffered. She loved his father and wanted another child.

Darlene sees the two children who live near her every day. She visits the son who lives in New Jersey every week. She says she'll see them this way until she dies. She only hopes she doesn't linger.

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What lessons might be drawn from the trials of Darlene Johnson? How does her experience speak to the myths mentioned above?

Certainly, heroin use put Darlene at increased risk of HIV infection. In all likelihood, she contracted the virus from a needle contaminated with blood from an infected friend or relative. But the decisions made by Darlene and women like her are linked to their poverty, to the racism that restricts options for African-Americans, and to their subordinate status as women. Certainly,

her sickness has more to do with poverty, racism, and sexism than with the "promiscuity" so central to myths about women and AIDS.

Darlene is a poor woman in a rich country. She lives in a nation with economic resources to meet not only the challenges of AIDS, but also those of drug addiction, child abuse, and the other pathologies that have marred her experience from the time she was a little girl.

Why, then, have Darlene and women like her been so woefully served at every step along the way? Why have prevention efforts ostensibly targeted to "at-risk" populations failed to reach Darlene and women like her? Why is the incidence of HIV in poor women of color rising exponentially?

One reason is the "masculinization" of the AIDS epidemic in this country. AIDS dollars are being spent— to the tune of several *billion* dollars per year in the United States alone— but they have been targeted away from women like Darlene. One of the functions of "obscuring paradigms" such as those outlined in the myths above is to misdirect the limited supply of funds. The end result, of course, is nothing for women like Darlene.

And the situation is even worse for poor women in *poor* countries, as the experience of Guylene Adrien suggests.

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Guylene

Guylene Adrien was born in Savanette, a dusty village in the middle of Haiti's infertile central plateau. Like other families in the region, the Adriens fed their children by working a small plot of land and selling produce in regional markets. Like other families, the Adriens were poor, but Guylene recalls that, when she was young, they "had enough to get by." She was the third of four daughters, a small family by Haitian standards.

It was to become smaller still: Guylene's younger sister died in adolescence of malaria. Guylene's oldest sister had four children, all of whom died before the age of five; unable to make a living, she eventually left for the Dominican Republic, to work as a servant. Guylene's other surviving sister continues to live with her